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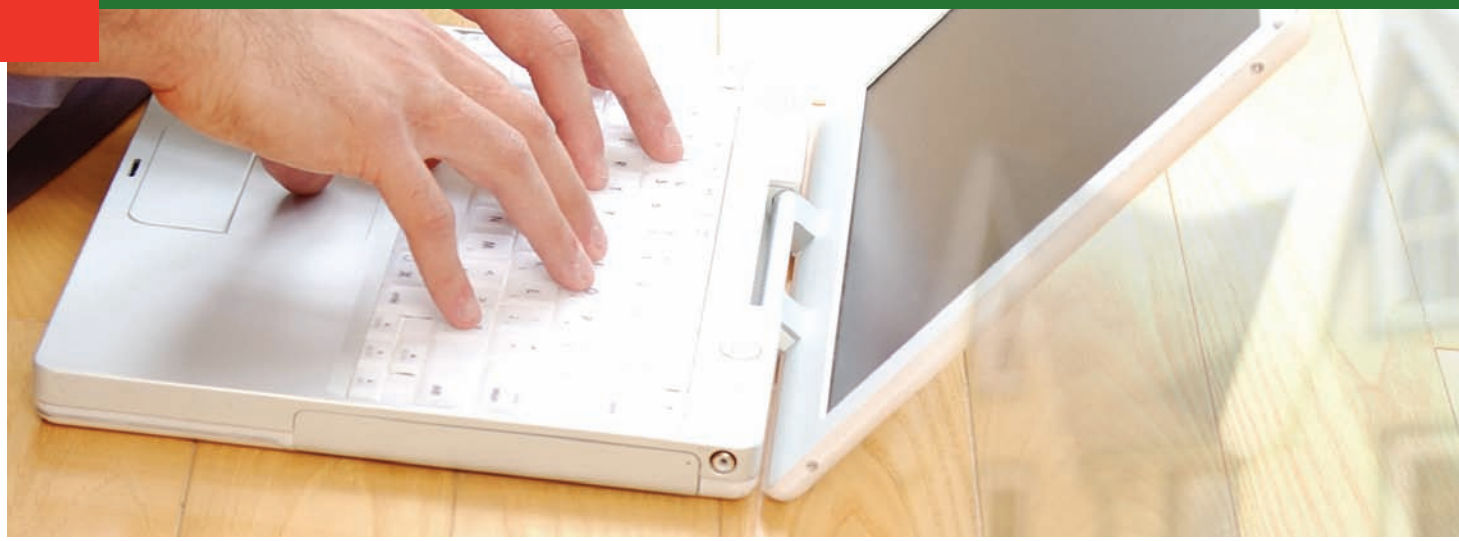

A Longitudinal Study of Housing for Mental Health Consumer-Survivors

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A Longitudinal Study of Housing for Mental Health Consumer-Survivors: Final Report

Submitted to Canadian Housing and Mortgage Corporation
December 31, 2008

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Abstract

This report describes a longitudinal study of the outcomes of two models of supported housing for individuals with serious mental illnesses: a high support model and a lower support model. The progress of 27 tenants at the two sites was tracked on measures of program satisfaction, social support satisfaction, mental health, physical health, and mastery over the course of one year. Measurements were taken at baseline, six months, and 12 months. In addition, interviews were conducted with tenants at baseline and twelve months to understand their goals and the reasons for their decision to move to the particular site they occupied. Significant improvements were found among tenants at the high support model of housing in the following areas: satisfaction with social support, perceptions of mental health, perceptions of physical health, and mastery. At the low support site, there were no statistically significant improvements. Interview data suggest that tenants in both high and low support models are mostly satisfied with their housing, which they consider to be of higher quality than other supported housing they have experienced. Data also suggest that participants are mostly concerned with safety and social interaction, rather than supports, at their supported housing site.

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Executive Summary

This report describes a longitudinal study of the outcomes of two models of supported housing for individuals with serious mental illnesses. Both models are focused on building community and one has on site support while the other has very little on site support. The progress of 27 tenants at the two sites was tracked over the course of one year, with measurements taken at baseline, six months, and 12 months. In addition, interviews were conducted with tenants at baseline and twelve months to understand their goals and the reasons for their decision to move to the particular site they occupied.

Background

Safe, secure, and affordable housing is recognized as one of the vital factors for recovery from mental health issues (Boydell, Gladstone, Crawford, & Trainor, 1999; Capponi, 2003; Carling, 1995; Nelson, Hall, & Walsh-Bowers, 1998; Rog, 2004; Tanzman, 1993). While ensuring adequate supply, quality, and affordability of housing for mental health consumer-survivors remains a central concerns, there are increased choices for housing from the days of the residential continuum, where consumer-survivors progress through a series of increasingly independent housing situations (Boydell et al., 1999). With increased choices comes a need for increased understanding of the effectiveness of these models and of the factors related to choice of housing model by consumer-survivors (Hopper & Barrrow, 2003).

Objectives

The objectives of this project are as follows.

1. To compare outcomes of the two housing models associated with well-being: social support and satisfaction with this support, physical health, mental health, hospitalization, and perceptions of mastery* of consumer-survivors residing in two housing programs (provided by the same organization) over three years.
2. To assess and compare consumer-survivor satisfaction with the two programs.
3. To explore factors that influence decision-making in housing.
4. To examine differences in outcomes and preferences of housing between those of South Asian background and those of other backgrounds.
5. To build capacity within an organization/community for research.

Method

As tenants moved into the new housing developments, they were asked to complete surveys measuring the following: satisfaction with their housing, satisfaction with social support, perception of mental health, perception of physical health and perception of mastery. Tenants were also invited to participate in an interview during which they were asked about their reasons for selecting the particular housing program they chose and about the needs they hoped to fulfill by living in their selected environment.

At six months following this baseline, the survey measures were repeated to track progress of tenants. A one year follow-up ensued.

* Footnote: subjective feelings of being able to control areas of one's life

Findings

At the high support site, there were significant improvements in the following areas: satisfaction with social support, perception of physical health, perception of mental health, and mastery. At the low support site, there were no statistically significant improvements, but two areas were trending toward improvement: perception of physical health and taking medication as prescribed.

When comparing cultural groups (South East Asian versus non South East Asian), the areas of improvement suggested some differences. While participants of both categories improved significantly in perception of physical health and in perception of mental health, participants of South East Asian background improved significantly in mastery while participants who were not of South East Asian background improved significantly in satisfaction with social support. It may be that these results suggest a merging of cultural focus on individualism or collectivism.

Interviews with tenants suggest that most participants are highly satisfied with their home, with most remarking that it is the best they have had in supported housing. The positive aspects of the housing as identified in interviews include: independence and choice; feeling connected and settled; safe, clean, comfortable living environment; and a supportive, structured well-resourced program.

When asked for the negative aspects of their housing, most participants said there was nothing negative. Those who did identify negative aspects identified the meal plan at the high support model and the lack of interaction at the low support model.

Participants identified that their choice of housing was based on safety and social interaction rather than on available supports.

Implications

It may be that the higher support model of supported housing leads to better outcomes for tenants. However, it is also possible that the changes among tenants at the lower support model may simply take longer to appear.

The focus on building community makes this supported housing organization unique. With the positive outcomes and the high levels of satisfaction, it may be a focus about which other organizations may wish to learn.

High quality housing, such as that in this study, is considered to have a significant impact on recovery.

Résumé

Le présent rapport fait état d'une enquête longitudinale portant sur deux modèles de logements avec services de soutien et leur influence sur la vie de personnes ayant une maladie mentale grave. Les deux modèles insistent sur le renforcement du lien social, mais un seul des deux offre aux résidents une prise en charge sur place, l'autre modèle n'offrant que très peu de soutien sur les lieux. Les progrès des 27 locataires des deux ensembles de logements ont été suivis pendant une année. Des données ont été recueillies au début de l'enquête, après six mois, et enfin douze mois après le début de l'enquête. De plus, deux séries d'entrevues ont été menées auprès des locataires, au début de l'enquête et après douze mois, dans le but de comprendre quels étaient leurs objectifs et les raisons de leur choix de logement.

Contexte

Il est admis que les logements sûrs, stables et abordables constituent l'un des facteurs essentiels pour le rétablissement des personnes ayant une maladie mentale (Boydell, Gladstone, Crawford et Trainor, 1999; Capponi, 2003; Carling, 1995; Nelson, Hall et Walsh-Bowers, 1998; Rog, 2004; Tanzman, 1993). Le maintien d'une offre adéquate de logements abordables et de qualité à l'intention des bénéficiaires de services de santé mentale demeure une préoccupation centrale. Or, il existe aujourd'hui un plus grand nombre d'options par rapport à l'époque du « continuum du logement », où ces personnes progressaient dans une série de logements leur offrant graduellement plus d'autonomie (Boydell et al., 1999). Ce nombre accru d'options entraîne le besoin de mieux comprendre la performance de ces modèles d'habitation et les facteurs liés au choix d'un modèle par les personnes ayant une maladie mentale (Hopper & Barrrow, 2003).

Objectifs

Voici les objectifs de l'enquête :

1. Comparer sur trois ans les résultats obtenus par deux programmes de logement offerts par le même organisme. Les facteurs liés au bien-être des résidents ont été comparés : soutien social et satisfaction par rapport à ce soutien, santé physique, santé mentale, hospitalisation et sentiment de maîtriser sa vie[*].
2. Évaluer et comparer la satisfaction éprouvée par les résidents à l'égard des deux programmes.
3. Explorer les facteurs qui influencent le choix d'un logement.
4. Examiner les différences dans les résultats et les préférences respectives relatives au logement des personnes originaires d'Asie du Sud-Est et de celles d'autres milieux socioculturels.
5. Développer le potentiel au sein d'un organisme ou d'un milieu aux fins de la recherche.

Méthode

On a demandé aux locataires de répondre à des questionnaires portant sur leur degré de satisfaction à l'égard de leur logement et du soutien social, leur perception de leur santé physique et mentale et leur sentiment de maîtriser leur vie. Les locataires ont également été invités à participer à une entrevue au cours de laquelle on les a questionnés sur les raisons motivant leur choix du type de logement et sur les besoins qu'ils espéraient combler en vivant dans le milieu choisi.

[*] Apostille : Jugement subjectif sur la capacité à maîtriser certains domaines de sa vie

Dans le but de suivre les progrès des locataires, ces questionnaires ont été distribués à trois reprises : au moment de l'emménagement dans le nouveau logement, après six mois, et enfin douze mois après le début de l'enquête.

Conclusions

Chez les résidents des logements assortis d'un important dispositif de soutien, on a constaté des améliorations substantielles dans les domaines suivants : satisfaction à l'égard du soutien social, perception de la santé physique et de la santé mentale, et sentiment de maîtrise. Inversement, chez les résidents des logements n'offrant que très peu de soutien, on n'a observé aucune amélioration appréciable du point de vue statistique, mais seulement une tendance à l'amélioration dans deux domaines : la perception de la santé physique et la prise des médicaments tel que prescrits.

La comparaison des communautés culturelles (Asie du Sud-Est vs ailleurs) a laissé entrevoir des différences dans les domaines d'amélioration. Bien que la perception de la santé physique et mentale se soit beaucoup améliorée chez tous les participants, on a noté chez les participants originaires de l'Asie du Sud-Est une nette amélioration dans le sentiment de maîtriser leur vie, et, chez les autres, une bien meilleure satisfaction à l'égard du soutien social. Ces résultats laissent peut-être entrevoir une tendance culturelle vers l'individualisme d'une part, et le communautarisme d'autre part.

Les entrevues avec les locataires donnent à penser que, dans l'ensemble, les participants sont très satisfaits de leur logement; la majorité d'entre eux ont indiqué qu'il s'agissait du meilleur logement avec services de soutien qu'ils avaient jamais occupé. Voici les aspects positifs des logements qui ont été mentionnés dans les entrevues : choix et autonomie; sentiment

d’appartenance et de stabilité; milieu de vie sûr, propre et confortable; et programme structuré avec un encadrement et l’accès à plusieurs ressources.

À la question sur les aspects négatifs de leur logement, la plupart des participants ont déclaré qu’il n’y en avait pas. Ceux qui l’ont fait ont mentionné les repas (logements avec soutien), et le manque d’interactions sociales (logements avec peu de soutien).

Les participants ont indiqué que leur choix de logement avait été fait en fonction de la sécurité et des contacts sociaux et non en fonction de l’aide offerte.

Implications

Le modèle de logement avec soutien a peut-être une influence bénéfique sur la vie des locataires. Cependant, rien n’interdit de croire que les changements chez les locataires du modèle de logement avec peu de soutien soient simplement plus lents à apparaître.

La priorité accordée au renforcement du lien social par l’organisme de logements avec services de soutien est unique. Vu les résultats positifs obtenus et le taux élevé de satisfaction des résidents, d’autres organismes pourraient vouloir s’inspirer de cette idée.

On estime que des logements de grande qualité, comme ceux sur lesquels a porté l’enquête, ont une grande influence sur le rétablissement des personnes ayant une maladie mentale.

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Introduction

This report summarizes the research activity and results from August, 2006 to December 15, 2008 for this CMHC-funded evaluation of housing for mental health consumer-survivors. A mental health housing organization in Toronto, Ontario began two new housing programs—one in January, 2006 with high levels of on site support and one in May, 2007, with limited on site support. This project is tracking, over the course of three years, the progress of participants of the new housing programs and comparing the outcomes of the two programs and tenants' satisfaction with them. The organization is also partnering with a South Asian community, so the project examines differences in outcome and preferences between those of South Asian background and others.

The Support Models

The organization in this study provides supported housing to individuals labeled with a mental illness. It has operated one apartment building since the early 1990s and opened a new building in January, 2006. This building offers the high support model and has 30 bachelor apartments, offices, a common lounge area, a common eating area and a common outdoor garden area. There is a full time Caretaker who lives on site as well as a Program Manager with an office on site, seven resource workers who provide individual and group support, planned activities and crisis intervention, and a Peer Mentor who provides supportive counseling, crisis intervention, and recreation support. In addition, there is an Executive Director and a Housing Administrator who are responsible for the new building as well as the original one. This program model has regular planned group activities, activity and skills groups, and a meal program where tenants eat breakfast (self-serve, facilitated by a peer) and the evening meal (prepared by a chef) together. There are monthly meetings for all tenants of the building and tenants are expected to take an active role in these and other aspects of the internal community. While tenants live in their own apartments, the group activities and common areas, as well as the focus on peer support, provide them with the opportunity to have both privacy and community.

At the newest building, operating from the low on site support model, tenants live in either bachelor or one bedroom apartments. The building has an office area that tenants can use for computer access and a common lounge with a television and a community kitchen. There is only one staff member assigned to this building and he is only present Mondays to Fridays 9am to 5pm. His role is more that of a building manager than of a support person although he does

provide practical support in accessing resources as well as community development support. The only planned community activities in this building are regular monthly tenant meetings (currently facilitated by the staff member) and recreational activities that the tenants plan for themselves.

A previous study (Grant, 2006) of the organization (when it only had the one building) found that the central feature of the organization was its focus on community and recovery from mental illness through engagement in this community. Further, this study identified three key traits of the organization that supported the community it creates: mutual respect, interdependence, and structured flexibility.

Background

With the proliferation of deinstitutionalization of people with mental health issues, housing has become an important consideration for those who formerly would have been institutionalized (Capponi, 2003; Carling, 1995). The first residences provided for those leaving psychiatric institutions, mostly boarding homes with little support or programming (Carling, 1995; Marshall, 1982; Simmons, 1990), were replaced or augmented by organizations providing an array of group homes combining structured programming with group living, often on a continuum of level of support (Nelson, Hall, & Forchuk, 2003; Parkinson, Nelson, & Horgan, 1999). This residential continuum, criticized for its inflexibility, impermanence and for an erroneous assumption of linear recovery from mental health issues (e.g. Goering, Sylph, Foster, Boyles, & Babiak, 1992; Rog, 2004), started to be replaced in the 1980s (Rog, 2004) by forms of supported housing that advocate increased integration into the community of those with mental health issues, increased normalization and permanency of housing, and greater choice in both housing and support models (Boydell & Everett, 1992; Carling, 1995; Goering et al., 1992; Hopper & Barrow, 2003; Walker & Seasons, 2002).

Safe, secure, and affordable housing is recognized as one of the vital factors for recovery from mental health issues (Boydell, Gladstone, Crawford, & Trainor, 1999; Capponi, 2003; Carling, 1995; Nelson, Hall, & Walsh-Bowers, 1998; Rog, 2004; Tanzman, 1993). While adequate supply, quality, and affordability of housing for mental health consumer-survivors remain central concerns, there are increased choices for housing from the days of the residential continuum (Boydell et al., 1999). With increased choices comes a need for increased

understanding of the effectiveness of these models and of the factors related to choice of housing model by consumer-survivors (Hopper & Barrrow, 2003). Limited research has been conducted into the comparison of different models of supported/supportive housing and results have been inconsistent (Rog, 2004) as to preferences and outcomes. Parkinson et al. (1999) suggest that there is a need to incorporate research and evaluation into program development to help understand more clearly the effects of various housing situations.

Furthermore, much of this prior research has been restricted to shorter term (e.g. Boydell & Everett, 1992; Goering et al., 1992; Jarbrink, Hallam, & Knapp, 2001; Nelson, Hall, & Walsh-Bowers, 1995) or, as Nelson et al. (1998) argue, cross-sectional studies (e.g. Brunt & Hansson, 2004; Walker & Seasons, 2002) and/or descriptive projects (e.g. Lipton, Siegel, Hannigan, Samuels, & Baker, 2000; Walker & Seasons, 2002), with no attention given to cultural differences. No studies were located that explored in-depth consumer-survivors' preferences for different types of housing by asking about their choices and providing them with the opportunity to assess their choices as their housing tenure progresses.

The Research Project

Goals and Research Questions

This project measures outcomes of the two housing models and explores the extent to which goals and needs are met for tenants. While the CMHC funding is for the first year of tenancy, outcomes and satisfaction will be measured over the course of three years.

The objectives of this project are as follows.

1. To compare outcomes of the two housing models associated with well-being: social support and satisfaction with this support, physical health, mental health, hospitalization, and perceptions of mastery (i.e., subjective feelings of being able to control areas of one's life) of consumer-survivors residing in two housing programs (provided by the same organization) over three years.
2. To assess and compare consumer-survivor satisfaction with the two programs.
3. To explore factors that influence decision-making in housing.
4. To examine differences in outcomes and preferences of housing between those of South Asian background and those of other backgrounds.
5. To build capacity within an organization/community for research.

This project will address the general research questions:

- How does a housing development with high levels of on site support compare to a housing development with little on site support in meeting the needs of those they serve?
- What are the comparative outcomes of the two housing models?

This general question has specific questions and hypotheses that focus the project. These are presented in Table 1.

Table 1: Research Questions and Hypotheses

Specific Questions	**Hypotheses**
How successful is each of the models of housing at the organization in meeting outcomes related to well-being?	Between entering the housing (baseline) and six months later consumer-survivors will report: • An increase in satisfaction with their social support. • Improvement in perception of mental health. • Improvement in perception of physical health. • Increased perceptions of mastery. • Decreased hospitalizations (number and length of stay). • Increased compliance with medications. Between entering the housing (baseline) and one year later consumer-survivors will report: • An increase in satisfaction with their social support. • Improvement in perception of mental health. • Improvement in perception of physical health. • Increased perceptions of mastery. • Decreased hospitalizations (number and length of stay). • Increased compliance with medications.
Are consumer-survivors satisfied with their housing support?	Satisfaction levels will generally be high and will increase between entering the housing and six months later, and again between six months and one year.

Specific Questions	Hypotheses
What needs and goals do consumer-survivors express and how well do they believe the programs meet them?	The two programs will be equally successful at meeting consumer-survivor needs.
Is there a difference in outcomes and satisfaction between those of South Asian background and those of other backgrounds?	There will be no difference in satisfaction between those of South Asian background and those of other backgrounds.
Is there a difference in outcome and satisfaction between the two housing programs?	There will be no difference in outcome and satisfaction between the two housing programs.
Who prefers housing with/without on site support?	

Method

As tenants have moved into the new housing developments, they have been asked to complete surveys measuring the following: satisfaction with their housing, satisfaction with social support, perception of mental health, perception of physical health and perception of mastery. Goering, Durbin, et al. (1992) assert the importance of social network to recovery from mental health issues, and Nelson, Hall, and Walsh-Bowers (1997) note that in evaluations of housing it is important to examine integration, quality of life (here, perceptions of physical and mental health) and empowerment or mastery. Tenants were also invited to participate in an interview during which they were asked about their reasons for selecting the particular housing program they chose and about the needs they hoped to fulfill by living in their selected environment.

At six months following this baseline, measures were repeated to track progress of tenants. A one year follow-up ensued. Any tenants hospitalized during the data collection period were asked to complete the measures and be interviewed when they returned to their homes.

Sampling

All tenants of the two new housing programs (n= 40) were invited to participate in the surveys. There are 30 units in the higher support building and 10 units in the lower support building.

Data Collection

A package of measurement instruments was developed. The coversheet for the package was created by the researchers and included demographic information. The PSR Toolkit Consumer Satisfaction survey is an instrument created by the International Association of Psychosocial Rehabilitation Specialists (IAPSRS, 1999) for those using mental health services and revised for Canadian use. It has good construct validity and its reliability is reported as .85 (IAPSRS, 1999). Participants were asked to rate their satisfaction with the housing program; for example, "The services offered at this program are relevant to my needs." To measure social support, we used an adapted form of the Revised MOS Social Support Survey, which has good construct validity and reliability of .9 (Hays, Sherbourne, & Mazel, 1995). Physical and mental health were measured using the Revised MOS Core Measure of Functioning and Well-being. The subscales of this survey, of which physical and mental health are two, are reported to have reliability ranging from .7 to .9 and the tool has good construct validity (Hays et al., 1995). Finally, to measure mastery, we used the Pearlin-Schooler (1978) Mastery Scale. Pearlin and Schooler report good construct validity and Turner and Noh (1988) found the reliability of this scale to exceed .7. This same scale was used by Nelson et al. (1997) in a comparison of three types of housing for consumer-survivors. Thirty-three participants completed this package at baseline, twenty-four at both baseline and six months, and twenty-seven at both baseline and one year.

The scoring for the surveys is explained in the results. For the MOS measures the instructions provided by the authors of the surveys were followed and scores were coded on a 100 point scale (Hays et al., 1995). This allows for greater sensitivity to variation in scores than a four or five point scale.

Sixteen tenants participated in an interview at baseline, twelve participated in an interview at six months, and eleven participated in an interview at one year. During the interview, participants were asked about their reasons for moving to their current housing, how they found out about the housing development, the supports they were hoping for in their current housing, and how they felt about their decision to move to their current home. They were also asked to

comment generally on the positive and negative aspects of their housing. The interviews ranged in length from 20 to 75 minutes and were co-facilitated by a tenant researcher and the Research Coordinator/Research Assistant or one of the co-investigators. Interviews were taped and transcribed verbatim.

Data Analysis

Surveys were analyzed using descriptive statistics for overall levels of satisfaction, social support, mental health, physical health and mastery. They have been compared using t-tests for differences across programs, time, and cultural background.

The qualitative data from interviews were analyzed using thematic analysis (Ezzy, 2002) with the assistance of NVivo software.

Results

Survey Measures

Participant Information

Of the 27 survey participants, 15 are female and 12 are male. The ages of participants range from 20-29 to 60-69, with most participants (15) being between 40 and 49 years of age. Participants were also asked about their cultural background. Of those who answered this question (23 in total), nine are of South Asian background, 10 Anglo Saxon, two Eastern European, one Hispanic, and one First Nations. Participants were not given these cultural categories; they were created according to responses.

Program Satisfaction

Participants were asked to complete the PSR Toolkit Consumer Satisfaction survey to assess their satisfaction with their housing. Items were summed to calculate a total satisfaction score which ranged from ten to 40 (10 questions, with highest satisfaction at 4 and lowest at 1). The mean (average) satisfaction score reported at baseline, within two months of moving into the new housing, was 28.81 and the median (middle) score 30 (sd=8.52). At six months, the mean satisfaction score was 31.48 and the median was 32 (sd=5.46). At 12 months, the mean satisfaction was 31.33 and the median was 31 (sd=4.66). In this case and all the other areas

below, the median is considered to be a more accurate measure of the central tendency because of the small numbers and fairly large variation in scores.

Satisfaction with Social Support

Participants answered a series of questions inquiring into the number of people who can fill various roles in their lives and their satisfaction with this number. Once again, scores on the individual questions were summed and the mean and median scores were calculated to represent the central tendency. Complete satisfaction with social support would receive a total score of 180 (18 questions, with 10 as complete satisfaction) and complete dissatisfaction a score of zero (18 questions with 0 as complete dissatisfaction. The mean satisfaction with social support at baseline was 104.89 and the median 120 (sd =42.15). At six months, the mean satisfaction with social support was 129.73 and the median was 131.5 (sd =48.58). At 12 months, the mean social support satisfaction was 126.33 and the median was 133 (sd = 38.5). These numbers suggest a trend of improved satisfaction between baseline and six months, when it seems to have leveled off as there is a small decline in the mean and a small increase in the median at 12 months. This likely reflects the fact that when a tenant first moves in, there is an immediate community of fellow tenants to meet and, likely, a group of new individuals to provide social support.

Perception of Mental Health

The Medical Outcomes Survey includes a subscale with 40 questions on mental health. In addition, the Advisory Committee recommended that we add three questions specific to schizophrenia—the diagnosis held by most tenants at the high support housing development. These three questions asked about hearing and seeing things others do not and about levels of anxiety.

The highest mental health score that participants could have is 4300 (43 questions with 100 being the best mental health) and the lowest is zero. At baseline, the mean mental health score was 2439.26 and the median was 2540 (sd =821.04). At six months, the mean mental health score increased to 2706.96 and the median was 2420 (sd=826.56). At 12 months, the mean mental health score increased further to 2785.19 and the mean was 2740 (sd =751.83). These numbers suggest trends of improving perceptions of mental health, particularly from baseline to six months.

Perception of Physical Health

Nine questions on the Medical Outcomes Survey inquire into participants' rating of their physical health. The highest ranking for each is 100, so the highest possible rating of physical health is 900 and the lowest is zero.

At baseline, the mean health score was 518.52, while the median was 500 (sd =193.72). At six months, the mean health score increased to 589.13 and the median increased to 625 (sd =197.26). At 12 months, the mean was 616.67 and the median 575 (sd =179.07). These numbers suggest a trend of improving perceptions of physical health between baseline and six months, with a small decrease at 12 months. It may be that, upon moving into supported housing, individuals are connected with healthcare providers who may help with some immediate health concerns, creating an immediate increase in one's perception of one's physical health. As health stabilizes, there may be a leveling off of this effect.

Perception of Mastery

We used eight questions from the Pearlin and Schooler (1978) Mastery Scale to assess participants' perceptions of their mastery. Participants were asked to rate themselves on a five point scale, which we converted to scores of 0, 25, 50, 75, and 100; thus, the highest possible level of perceived mastery was 800 and the lowest was zero. This method of scoring was chosen to make the variation in scores similar to the physical and mental health measures.

At baseline, the mean mastery score was 434 and the median was 475 (sd =202.44). At six months, the mean mastery score had increased to 486.36 and the median to 485 (sd=200.56). At 12 months, the mean mastery score continued to increase and was 500.74 with the median almost identical at 500 (sd =188.71). Thus, it does appear that there was an increasing perception of mastery among participants.

Medication

Participants were asked how frequently they took their medication as prescribed. This was part of the MOS Outcomes questionnaire and so was scored on a five point scale (Definitely true, Mostly true, Don't know, Mostly False, Definitely False), which was converted to 0, 25, 50, 75, and 100. Thus, the highest score for taking medication as prescribed was 100 and the lowest was 0. At baseline, the mean score for medication was 96.3 and the median 100 (sd=9.05). At six

months, the mean was 93.48 and the median 100 (sd=21.6). At twelve months, the mean was 98.15 and the median remained at 100 (sd=6.7). While the differences are small, it does appear that there may be a trend toward lower compliance with medication between baseline and six months (and higher to 12 months).

Days in Hospital

At each data collection time, participants reported on the number of days spent in hospital in the previous 6 months. At baseline, the mean was 15.08 and the median was 0 (sd=31.83). At six months, the mean number of days in hospital fell to 6.24 with a median of 0 (sd=20.19). At twelve months, there was a further drop, as the mean fell to .89 while the median remained at 0 (sd=2.99).

Table 2 summarizes the descriptive results for the entire sample.

Scale	**Highest possible score**	**Mean at baseline**	**Median at baseline**	**Mean at six months**	**Median at six months**	**Mean at 12 months**	**Median at 12 months**
Program Satisfaction	40	28.81	30	31.48	32	31.33	31
Social Support Satisfaction	180	104.89	120	129.73	131.5	126.33	133
Mental Health	4300	2439.26	2540	2706.96	2420	2785.19	2740
Physical Health	900	518.52	500	589.13	625	616.67	575
Mastery	800	434	475	486.36	485	500.74	500
Take medication as prescribed	100	96.3	100	93.48	100	98.15	100
Days in hospital	180	15.08	0	6.24	0	.89	0

Table 2: Summary of survey scores for entire sample

Several of the differences tested were statistically significant, which means that the change is not likely to be due to chance alone.

- Satisfaction with social support increased significantly at both the six month [t(21)=2.5, p=.021] and 12 month [t(26)=2.9, p=.007] times as compared to baseline.
- Mental health scores improved significantly at both the six month [t(22)=2.8, p=.01] and the 12 month [t(26)=4.3, p<.001] times.
- Physical health scores improved significantly at both the six month [t(21)=3.6, p=.001] and the 12 month [t(26)=3.8, p=.001] times.
- Mastery scores improved significantly at both the six month [t(19)=2.47, p=.02] and the 12 month [t(24)=2.98, p=.01].
- Days in hospital decreased significantly between baseline and twelve months [t(23)=2.19, p<.05].

Comparison between Sites

Using Independent Samples t tests, the two sites were compared on all outcome measures at each of the three time periods. In this case, we were comparing the tenants at one site to the tenants at the other site at three points in time. There were no statistically significant differences between the two service delivery models on any of the variables at any data collection time, which means that the tenants at each site were similar to one another.

Next, the two sites were split and the changes examined for each site separately. In this case, we were comparing each individual site to itself across points in time to see if each changed over time. Using Paired Samples t tests with the two sites split, the following results were found.

High Support Model

The following statistically significant differences were found at the high support site:

- Satisfaction with social support increased significantly at the 12 month time as compared to baseline [t(14)=2.265, p=.04].
- Perceptions of mental health improved at both the six month [t(11)=2.6, p=.025] and the twelve month [t(14)=4.7, p<.001) times as compared to baseline.
- Perceptions of physical health improved at both the six month [t(11)=3.06, p=.01] and at the twelve month [t(14)=3.6, p=.003] times as compared to baseline.
- Mastery improved at the twelve month time as compared to baseline [t(14)=2.8, p<.05].

Low Support Model

There were no statistically significant differences found at the low support site. Of note, however, are two variables:

- Changes in perceptions of physical health were trending toward being significant between baseline and six months [t(10)=1.99, p=.074]
- Taking medication as prescribed was trending toward a significant improvement between baseline and 12 months [t(11)=1.92, p=.082].

It thus appears that the changes noted within the whole sample were actually most common among the participants from the high support housing model. The fact that tenants at the higher support model have better results than those at the low support model is important information with some important program planning implications. It can be interpreted in one of two ways: either the tenants at the low support model are not improving (which may mean that they are not being provided enough support); or the changes among the tenants in this group will take longer to appear.

Comparisons between Cultural Groups

Scales were compared according to participants' identified culture. For the purposes of these comparisons, participants' culture was transformed into a dichotomous variable: Southeast Asian and Not Southeast Asian. There were no statistically significant differences at the .05 level (i.e., differences that can be attributed to anything other than chance) on any of the outcome measures at baseline, six months, and twelve months. Of note, however, is that Program Satisfaction at baseline was trending toward being higher among Southeast Asian participants [t(22)=1.83, p=.081].

The changes within the two cultural groups were examined separately. The following statistically significant changes were found.

Southeast Asian Participants

- Perception of mental health improved significantly from baseline to twelve months [t(8)=3.56, p<.01].

- Perception of physical health improved significantly from baseline to twelve months [t(8)=2.62, p=.03]
- Mastery increased significantly from baseline to six months [t(8)=2.6, p=.03]

Non-Asian Participants

- Satisfaction with social support increased significantly at the six month [t(11)=2.2, p=.047] and the twelve month [t(15)=2.11, p=.05] times as compared to baseline
- Perception of mental health improved significantly from baseline to twelve months [t(15)=2.7, p=.016]
- Perception of physical health improved significantly at the six month [t(11)=3.07, p=.011] and the twelve month [t(15)=3.46, p=.003] times as compared to baseline.

Participants in both groups improved in both mental health and physical health, but diverged in two areas: Southeast Asian participants also improved in mastery while non-Southeast Asian participants improved in satisfaction with social support. As will be discussed below, these differences may represent a merging of Southeast Asian and non-Asian cultural traits. Southeast Asian participants may be improving in areas related to a more individualistic approach while non Southeast Asian participants may be improving in areas related to a more collectivist approach.

Interviews

During the interview, participants were asked about their reasons for moving to their current housing, the supports they were hoping for in their current housing, and how they felt about their decision to move to their current home. They were also asked to comment generally on the positive and negative aspects of their home as they experienced them at this time. As participants are quoted, they are named with a pseudonym they have chosen and are identified by the site (high support=HS and low support=LS). The themes reported are the same for high support and low support tenants; except for where indicated, there was no identifiable variation in a divergent analysis (i.e.. an analysis that compared the two sites, looking specifically for differences).

Reasons for Moving To Current Housing

Three main reasons for moving to the housing development were cited by participants: they were *looking for their own space*, they liked the idea of *joining a community*, and/or they had *negative experiences in their previous housing*.

Referring to her reasons for moving to the building, Nicole (HS) said, "The main reason I took [the organization] over even a group home is that I've always wanted to live in my own place 'cause I feel like I can actually handle being on my own."

While many participants noted the benefits of moving to their own apartment, most also referred to the community atmosphere that is part of the organization. Brendan (HS), for example, referred to it this way:

> "I liked the idea because some places I've lived in before there was, like, very little support and I was going through the tail end of a bout with depression and I thought it would be good that, uh, the sense of community, and I liked in the way of making friends and having sort of like a social network and support system that could carry me through, you know, for a while."

Brendan compared his current home to previous homes, noting the positive difference in social support that he currently enjoys. Several other participants also compared their current housing to previous negative experiences, citing these negative experiences as contributing factors to choosing their current home. Participants described former housing as unsafe and loud and mentioned problems with former roommates. For several individuals, this had negative effects on their mental health. For example, Sam (LS) described his former home:

> "The place was dirty, there was no actual support…and it was infested with bugs, cockroaches and…the…complex was about hundred twenty units…and the people were bad: there was drunkenness, there was…drug dealers coming and going all the time, there was loud music, people were stealing from each other and the thing was, I almost felt sick again."

Supports Participants Were Looking For

Participants were asked to describe the sorts of support they were looking for in moving to their current home. They mentioned several forms of support, expanded below; however, several participants noted that they really were not looking for supports: that this was not a consideration in choosing a home. It appears that the safety, physical appearance, and atmosphere were more important than the actual supports provided. Sam (LS) explained this when he said, "Well, I was not anxious about the support as much as I needed a decent place to live, a clean place where you do your best."

Many participants mentioned that they were looking for a "safety net," people that would be around them in case of poor mental health or loneliness, noting that this makes them feel more secure. Ivonne (HS), for example, said:

> "But if, because I feel I, when I have some trouble, I can get the help, this kind of safety net, you know, it is kind of let me feel security here, you know, so, I feel more comfortable…Because I know that someone can look after me when I need, so I feel… I feel secure."

Participants also spoke of wanting encouragement and practical support with tasks like paperwork. Brendan (HS) spoke of both these supports when he expressed

> "Well, when I moved in, there was the support that was mentioned was sort of, from the different resource workers, and they decided to have everyone assigned a worker, I was just sort of uh, you know, just wanting the occasional bit of, you know, some encouragement, some help with practical things."

Others spoke about the appeal of joining a community as the support they were looking for. Jim (HS), for example, said:

> "I wanted to learn more about myself, and the community, and what all this community support was about and now I'm seeing that first hand what community support's all about and I like what I see and I want to be a part of it more than ever."

How Participants Feel About Decision to Move to Current Home

Almost all participants said that they believed they had made a positive decision in moving to their current home. Many, in fact, said that moving to this location was better than they had expected. Ivonne (HS), for example, said:

> "Yes, yes, it is a good decision. Before I moved here…I am not…so…so, I do not want to move here, so…but my social worker talk to me several time about this, so I decide to move here. So, I actually, I didn't expect too much from [the organization], but after I move here, I feel really comfortable to move here."

Will (LS) saw his move as the best that he could find at this time, saying, "I'm pretty happy. This is pretty close to as good as it gets for somebody in my situation so I'm pretty happy with it."

A few participants mentioned that the decision to move to their current home was a positive one temporarily but that they would likely be moving in the future so that they could have more independence. Brendan (HS), for example, weighed the advantages and disadvantages of living in his current home and noted, "I think in a way the good with the bad; I think it was a good move. Eventually I'd like to get out and be more independent."

Positive and Negative Aspects of the Housing Support

Participants spoke in great detail about the positive and negative aspects of their current living environment, with the great majority providing an extremely balanced view of their home.

Positive Aspects

Participants mentioned many positive aspects of living at their current home and many of these were highlighted as being in direct contradiction to experiences in other living situations.

Many participants noted that they appreciate that living at the organization allows them *independence and choice*. May (HS), for example, said that she enjoys not being surrounded by people all day, noting, "So I can do whatever I want in my own room."

Participants noted that this independence and choice are in the context of a community environment and that it is this combination of community and independence that they most

appreciate. Many participants stated, as Max (HS) said, that they chose to live at the building "because they have good community, society and good mixture of privacy and community living."

The community to which Max referred was mentioned by almost all participants as one of the benefits of the organization. It appears from these interviews that *community helps people to feel connected and settled*. Rob (LS) explained this very simply: "It is a community. I like community very much." Jim (HS) noted that this intentional community is helping him to grow:

> "Since I been here I play cards, I went to outings, I went to watch movies, ate popcorn, ate cups, juice, coffee, had discussion with people, been to meetings, staff, people that live here meetings. So I listen. We've done things and I've grown from that in the last month from watching everybody else and now it's my turn. I want some of it and learn how to do it."

In discussing the community atmosphere, participants noted the importance of their housing being long-term, of the relationships with other tenants that help to ensure they don't get lonely, of the opportunities for employment, and of the overall friendly atmosphere. Brendan (HS) pointed out the interrelated aspects of community that tenants enjoy:

> "I find that the times I, I'm sort of on my own with my friends outside of here but it is nice to be able to… have some organized activity that I can take part in…If I go through a period where I'm, where I would normally in another atmosphere sort of tend to isolate myself, here I , with all the people around, it's a little easier to reach out to other people. And being involved and eating together with other people, it gives you sort of a connection that… you can take advantage of in order to make friends, by talking to people when you're around them, go the activities and it's really a good opportunity for me to make more friends, which is what I needed to do."

The physical aspects of the apartment building were also mentioned by several participants as positive aspects of living there. In particular, participants noted that it was a *safe, clean,*

comfortable living environment. They appreciated the location (convenient and off the main street), the food, the cleanliness and newness of the building, and their feeling of safety. May (HS) commented, "it is very clean and then this is the new building…it is good for me," while Rob (LS) called it "comfortable".

Although participants, as noted above, were not necessarily looking for supports when they moved to the apartment building, this was also mentioned as a positive aspect of the living situation. In their interviews, participants described a *supportive, structured, well-resourced program*, mentioning supportive staff, amenities such as food and furniture, programs and activities all offered in, as Sam (LS) said, "a tight ship."

When participants at the high support location discussed the safe, clean, comfortable living environment, they almost always made reference to the staff working there. For example, Brendan described the beautiful atmosphere at the building and then said, "Well, that was additional blessing when I saw that there is 6, 7 support workers, you could actually talk to them."

Similarly, Ivonne (HS) noted the importance of the staff members and how different the support is from her previous homes:

> "They have the, also resource worker, you know, some people can look after us. If I live outside, I have to dealing with roommate, and also the landlord. You know, sometimes, they could gave me some trouble, but I don't know how to deal with it. So if I live here, I have someone, I can if I have problem, I can go to ask them and ask help, ya…Living here as…actually, it is kind of support. For example, I, if I have some problem…my resource worker help…teach me English and he also, she also help me do my assignment as a, you know, sometimes I ask resource worker where to buy stuffs."

It was clear from the praise from participants and from the extent to which they appreciated their home, that they felt that the community where they live is *unique among supported housing*. Many participants used the identical phrase: "I've never heard of anywhere so good." Nicole (HS) described it in this way:

> "You do actually feel that it's home and privileged that you be in [the organization] because it's not like other housing projects and stuff like that, it's a nice community of people here…living with and the staff are there for you…hey, what can I say? It's just a great place."

Sam (LS) described some of the positive effects for him of living in the building:

> "I enjoy myself and I pursue the things in life, and I am actually more productive than I used to be. Although I have had diagnosis of more illness, physical and all, yet I am happier than I have ever been past three years, four years."

Negative Aspects

In comparison to the vivid descriptions of the positive aspects of the program, participants had relatively little to say about negative aspects. The majority of participants could not find anything negative to say, so the most common response to the negative aspects of the model of supported housing was *nothing.*

If participants from the high support program did mention areas that they would like to see changed, they were most commonly related to the *meal program* at the high support building: that it is too expensive, that it is inflexible, or that it interferes with a tenant's ability to work. Ivonne (HS), for example, noted that eating together is good for her mental health and that she appreciates the good food, "but the problem is that I feel the food program is a little bit expensive." Max (HS) explained that he will likely move because of the inflexibility he finds in the meal program:

> "I would like to stay here except the fact that I am going back to school…I am most likely going to be working in the evening time…And I talk to [a staff member] about working in the evening time and not participating in the dinner program here, and [the staff member] said that if I live here, I have to participate in the dinner program, that is mandatory, so she said that if I don't want dinner program and I have to work in the evening time, she tell me that I should move into a new building where there is no meal plan-- so I can work in the evening time."

Participants also expressed that one of the positive aspects of the organization—the community—can also be difficult, noting that *relationships can be challenging.* A few participants stated that they find sometimes that there are too many people around, while another said that getting along with a resource worker can be difficult, and another complained that the main floor washroom should be open to everyone and not just staff.

At the lower support building, participants were more likely to mention that they would like *increased interaction* with fellow tenants. Frankie (LS) said, "I'd like to see more community activities in the [common] room."

At the lower support building, one of the tenants mentioned that they expected more integrated housing and were disappointed to discover that only individuals with mental illnesses were housed in the building. Aofe (LS) said, "It wasn't what they told me it was going to be."

(Just a note to clarify if the LS site was a case of scattered integrated units in a larger housing development or was it rent supplement for 100% of tenants in one building.? The original proposal gives the impression of non dedicated buildings, e.g., *" a rent supplement program can be considered housing as housing because it provides housing for consumer survivors in locations not dedicated to those with mental health issues")*

Perhaps due to the newness of the living environment, some participants noted that they feel some uncertainty about their living situation, wondering about the availability of supports in times of crisis, the safety of the neighbourhood, and where they would go if this home does not work out. Ivonne (HS) expressed the concern of several participants when she said, "You know if I sick, I hope someone can look after me."

Finally, some participants raised concerns about theft in the buildings. Homer (LS) explained, "Well, there's been like some theft or whatever and stuff like that. Then it sets up other tenants maybe getting upset with other tenants guessing."

Organizational Capacity for Research

One of the objectives for this project was to build capacity for research within the organization. To work toward this goal, the researchers hired tenant researchers who participated in the planning of the project, the oversight of the project, and the data collection.

Formal training was provided by the researchers to the tenant researchers on five different occasions. This training included: confidentiality, research methodology, survey administration, organization of materials, operating equipment, and interviewing skills.

Eight tenant researchers were involved in the project at various stages, with the most participation by five researchers (four at the High Support site and one at the Low Support site). At the outset, the plan was to transfer increasing amounts of responsibility for the research to the tenant researchers. At the High Support site, this did not occur because of the tenant researchers' stated lack of comfort with this. As a result, the surveys and interviews were co-facilitated with a tenant researcher and a community researcher, a graduate student Research Assistant, or one of the researchers. From the tapes, it was obvious that tenant researchers became much more comfortable with interviewing throughout the process, with a great increase in their participation and ability to provide prompts to interview participants. At the Low Support site, after initial co-administration of the surveys, the tenant researcher was able to independently administer the surveys. The interviews, with which she was much less comfortable, were co-facilitated with one of the researchers.

The researchers asked the tenant researchers to comment on what they liked about being involved in the project. Four main areas represent their answers: developing skills, feeling connected to the research topic, enjoying the relationships built among research team members, and feeling valued.

We believe that there has been growth in the capacity of the organization to conduct research. Whereas for this project, a great deal of training of tenant researchers was required, it is likely that future projects will benefit from individuals capable of conducting interviews and administering surveys. In addition, it is likely that, having experienced the research process, the organization's tenants and staff members may be more likely to consider future research projects.

Discussion

The results from the study suggest that tenants in both the high support and low support buildings are satisfied with their living situation and appreciate the supports that are offered. In comparison to other homes in which they have lived, it appears that they find their current home to be far superior and particularly appreciate the safe, comfortable living atmosphere with an available community of fellow tenants and supportive staff members.

In addition, results from the outcome measures analysis suggest support for previous authors' assertion of the importance of safe, secure housing in recovery from mental illness (Boydell, Gladstone, Crawford, & Trainor, 1999; Capponi, 2003; Carling, 1995; Nelson, Hall, & Walsh-Bowers, 1998; Rog, 2004; Tanzman, 1993). The improvements in most areas from baseline to six months and from baseline to 12 months suggest that the high support model of supported housing is having desired effects: increased satisfaction with the program, perceptions of increased social support, improved mental health, perceptions of improved physical health and of mastery. As noted in the results, there were no statistically significant differences found at the low support site. The fact that the changes are not significant at the low support model suggests either that the particular tenants at this location may require higher levels of support or that the changes will take longer to see at this site.

The increased satisfaction with social support is consistent with interview comments describing the importance of community—relationships with both other tenants and staff members. This focus on community as well as the structured, supportive environment in the high support program may also be contributing to improved perceptions of physical and mental health.

When the participants were split into two cultural groups (Southeast Asian and not Southeast Asian), there were some differences in outcomes. Both groups saw improvement in mental health and perceptions of physical health. Southeast Asian participants also reflected an increase in feelings of mastery, while non Southeast Asians reflected an increase in satisfaction with social support. This is an interesting difference, which may reflect a merging of two different cultural traits (individualism and collectivism). If the eastern group already had a feeling of collectivism, then the biggest difference could be a focus on more individualism (thus, an

increase in personal mastery). If the western group already had a focus on individualism, the biggest difference could be a focus on more collectivism (thus, an increase in social support).

Recommendations

Perhaps being expected to help develop and sustain a community has the benefit of building perceptions of mastery and satisfaction with social supports, thus benefiting both mental and physical health. Other organizations may wish to encourage the development of an intentional community at their sites, putting resources into community development. It appears from the results of this study, however, that regularly provided support is an important part of the positive outcomes. This likely helps to contribute to the structure that many participants noted as a positive aspect of their experiences.

As tenants mentioned in their interviews, the organization in this study is unique among supported housing organizations, with its focus on building community. With the improvements in social support, physical and mental health, and mastery, it is one that it is important to study and understand. The focus on community building, unique in Canada, is a model from which other organizations may want to learn.

Next steps

While the CMHC support has ended, the researchers will continue to follow up with the tenants at the three year point to see if there are any further changes or if participants have maintained their changes. Given that the significant changes were only seen among tenants at the high support model, it will be interesting to identify whether the low support participants have similar changes but over a longer period of time, or if they do not reflect similar changes.

In addition, at the three year data collection point, the researchers will ask participants what they mean by community so that the clarity of the model of support is increased.

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Do you plan to annex any of the questionnaires?

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